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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work Hardening 3 X 2 Weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Chiropractor with over 13 years of experience

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who sustained an injury on XX/XX/XX. The claimant struck the right knee xxxxx The claimant was diagnosed with concussion without loss of consciousness and cervical disc bulge, cervical radiculopathy, lumbar radiculopathy, disc protrusion of the lumbar spine, rotator cuff sprain and strain, bilateral knees sprain and strain, left elbow sprain and strain, post traumatic headache and dizziness, post traumatic myospasm, and status post motor vehicular accident.

xxxxx: MRI Brain W/O contrast. **Impression:** 1. Unremarkable MRI brain. **Impression:** 1. C3/4 central posterior protrusion-subligamentous disc herniation measuring 1mm in AP dimension indenting the thecal sac. 2. C4/5 central posterior protrusion-subligamentous disc herniation measuring 0.5 to 1 mm in AP dimension indenting the thecal sac.

xxxxx: Initial report. **Medications:** Lisinopril. **Neurological Evaluation:** Found no abnormality on examination of speech or mental state. Face was symmetrical. Bye movements were full. There was no drift of outstretched arms. Found no focal or neurological deficit. No significant reflex changes. There were also no cerebellar signs or sensory abnormality. **Plan:** Ordered EEG, MRI of the lumbar spine and EMG of the upper and lower extremities.

xxxx: Office visit. **Impression:** Bilateral lateral plantar neuropathy. This electrodiagnostic finding is clinically compatible with Tarsal Tunnel Syndrome. Suggest clinical correlation. 2. Bilateral L3L4, L4L5 Radiculopathy.

xxxxx: EEG. **Impression:** This EEG is remarkable for spike looking like discharges which could be suggestive of encephalomalacia and could have epileptic form potential.

xxxxx: Office visit. **Impression:** Right Ulnar Motor Neuropathy. Left C5C6 Radiculopathy suggested clinical correlation.

xxxxxx: MRI Lumbar Spine. **Impression:** Evidence for posterior annular tear with a high intensity zone at the L3/4 and L4/5 levels. This could result in discogenic pain at both these levels. This is suggestive of an acute findings. There is associated 3 mm central disc protrusion/herniation at both segments. The anterior margin of the thecal sac is contacted and partially effaced. There is some mild to moderate compromise of the left and right lateral recesses, mild to moderate compromise of the neural foramina. Could potentially result in primarily L4 and L5 symptoms. The spinal canal is also borderline stenotic at the L3/4 segment. 2. Mild to moderate compromise of the left neural foramen at L5/S1 due to 2mm of lateralizing disc material. This could result in left-sided L5 symptoms.

xxxxxx: MRI left knee. **Impression:** Abnormal linear signal posterior horn of the medial meniscus with a small oblique undersurface tear. There is mild cartilage loss medial compartment. Normal signal is maintained. 2. There is some patchy marrow edema involving the anterior margin of the distal metaphysis of the femur, likely represents patchy edema related to the patellofemoral compartment. Otherwise, the patellofemoral compartment is normal in appearance.

xxxxxx: Follow up. Claimant reported his neck and back were somewhat better, and generally speaking, the patient's symptoms are improving. Neurologically: Claimant's BP was normal. Head and ENT examination is normal. Cranial examination is normal. **Medications:** Elavil 10mg, propranolol 40mg, Ativan 0.5 mg.

xxxxxxx: Follow up. Claimant is doing better. Claimant reported fatigue and insomnia. Claimant still suffers from sequelae of post-concussion. **Impression:** Post-concussion syndrome, Anxiety disorder.

xxxxxxx: Follow up. **PE:** Neurological Examination: Strength was 4+/5 for left deltoids, quadriceps, and Ext. Hallucis. All other myotomes were normal. (5+/5+). Sensory exam: prasthesia of lower extremities at L5-S1 Distributions. Reflexes: +2/+2 at biceps, triceps, brachioradialis, patella and Achilles. **Musculoskeletal Examination:** Examination of cervical spine revealed loss of lordotic curvature due to muscle spasm pain with extension range of motion. Tenderness of posterior cervical muscle and trigger points in suboccipital region, right trapezius and splenius muscles. Shoulder depression test provoked pain in neck, and right shoulder and cervical distraction test for myospasm positive bilaterally. Examination of right shoulder revealed tenderness of right supraspinatus muscle biceps tendon and GH joint upon palpation. Apley's test provoked pain to his right shoulder region. Examination of left elbow revealed tenderness of lateral epicondyle, trigger points in left brachioradialis muscle. Examination of the lumbar spine revealed an increase in lumbar lordotic curvature in standing position. ROM is limited in flexion, extension and provoked low back pain bilaterally. Kemp's test provoked low back pain on the left. Bechterew's test provoked pain to his low back and lower legs. Braggard's test provoked low back and left leg pain. Examination of the left knee revealed mild tenderness of joint line, patellar tendon and MCL upon palpation. **Diagnosis:** 1. Concussion w/o loss of consciousness. 2. Cervical disc bulge. 3. Cervical radiculopathy. 4. Lumbar radiculopathy. 5. Disc Protrusion-Lumbar spine. 6. Rotator cuff sprain/strain right. 7. Knee sprain/strain-bilateral. 8. Elbow sprain/strain-left. 9. Post traumatic headache and dizziness. 10. Post traumatic myospasm. 11. Status post MVA.

xxxxx Initial Evaluation. **Progress:** Claimant continues with chronic pain in his lower back and has not seen much of improvement so far, however, he wants to return to work. We will accommodate him. **Medications:** Lorazepam 0.5, propranolol 10mg, Elavil 10mg.

xxxxx: UR. Rationale for denial: ODG states that approval of the program should include evidence of a screening evaluation. During my conversation with xxxxx, Azhdarinia's designee, she indicated that the claimant completed a course of chronic pain management xxxxx. The patient reportedly underwent a designated doctor's reevaluation on xxxxxthat supposedly recommended additional work hardening. There is no current documentation of that recommended additional work hardening. There is no current documentation of that

evaluation. Furthermore, there was no recent documentation of psychological evaluation. It was agreed that prior to certifying any work hardening that the report from the most recent designated doctor reevaluation and an updated psychological evaluation would be appropriate. Therefore, the request for work hardening 3 times a week for 2 weeks is neither necessary nor appropriate.

xxxxx: ERGOS Evaluation report. **ROM**: Claimant presents ROM of the lumbar spine that is a normal level representing 80% of full ROM with the exception of right rotation that is limited to 30% of full range. **Recommendations:** The claimant has contracted an injury to his cervical, lumbar spine and knee resulting in lumbar disc protrusion confirmed by MRI and EMG/NCV correlation. He has been treated with PT and medication with significant relief and partial resolution relating to his lumbar spine. He has developed stress and anxiety that have significant association with PTSD that is related to his accident. He should continue to consult with his psychiatrist and psychologist for these deficits. It is further recommended that he attend a Work Hardening Program to improve his opportunity to return to work place without restrictions and gain strength and stability and his further well-being.

xxxxx Office visit. **Progress:** Since last visit the claimant has had numerous aches and pains. He is driving up to 45 minutes an hour without vomiting. He used to vomit before when he got into a car. He finished chronic pain program and is awaiting for work hardening.

xxxxx: UR. Rationale for denial: The current clinical guidelines indicate that the necessity of work hardening is dependent upon evidence of improvement followed by plateau with prior physical therapy trial. The guidelines also indicate the necessity of current functional capacity evaluation. The records supplied do not contain evidence of improvement followed by plateau, or, evidence of a current functional capacity evaluation to support the necessity of the requested work hardening program.

xxxxx: Discharge Summary. Claimant has completed 20 sessions of Chronic Pain management program which he states helped him significantly to better cope with his injury. He continues to reports a pain level of 4/10 to the cervical, low back and left knee. He wants to return to work, however, he still have trouble lifting, bending, pulling, and standing for long durations. He reports sleeping better about 6 hours nightly, however, is awakened by the back pain. He is less depressed, isolated, lethargic, and motivated to return to work full-time, however, he continues to endure a 4/10 pain level. **Recommendations:** It is strongly recommended that this patient be admitted for the behavioral treatment: 10 sessions of the Work Hardening Program 1 x daily two weeks.

xxxxx: Pain Management report. The patient continues to complain of pain in wrist and radiates to palm; worsening. He is status post right carpal tunnel injections; good relief of symptoms. The patient has dreams regarding the accident. He can't drive; sometimes he will slam on brakes without warning. The patient does have phantom pain in right ring finger and a bad itch.

xxxxx: Follow up report. **Neurological Examination:** +5/5 bilaterally for all but the extensor hallicus rated at +4/5 bilaterally. DTR's were +2/+2 bilaterally. Sensory distribution showed that lateral leg, dorsum of the foot and lateral malleolus were hype-esthetic on the left. **Musculoskeletal Examination:** Examination of cervical spine revealed loss of lordotic curvature due to muscle spasm. Tenderness of posterior cervical muscle. Pain is elicited on cervical distraction with spasm posterior bilaterally. Examination of the right shoulder revealed tenderness of right supraspinatus muscle, biceps tendon and GH joint upon palpation. Pain with abduction, flexion and extension ROM. Examination of left elbow revealed mild tenderness of lateral epicondyle upon palpation. Examination of the lumbar spine revealed an increase in lumbar lordotic curvature in standing position. ROM is limited in flexion and extension with pain provoked at the low back, bilaterally. Heel and toe walk elicited low back pain. Examination of the left lower extremity presented pain a the lateral leg, dorsum of the foot and the lateral malleolus and the knee revealed mild tenderness of joint line, patellar tendon and MCL upon palpation. Examination of the right knee is negative for pain, tenderness and spasm and ROM showed no limitation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous determination has been upheld. Per ODG Guidelines, the current documentation does not currently support a work hardening program for six visits. Criteria for admission to a work hardening program recommend a valid FCE, which is currently not documented in the records reviewed. Job demands should show valid mismatch between documented, specific essential job tasks and patient's ability to perform these required tasks to support a work hardening program. ODG Guidelines also recommends ruling out surgery/injections that could be warranted to improve function prior to considering a work hardening program. A surgical consult should be considered with neurological deficits noted on xxxxxx exam of the lumbar spine and lower extremities combined with MRI of the lumbar spine that includes disc herniation's with mild to moderate compromise of neural foramena at the lower lumber levels. Therefore, the request for Work Hardening 3 X 2 Weeks is non-certified.

ODG Guidelines:

Criteria for admission to a Work Hardening (WH) Program:

(1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a prescription has been provided.

(2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.

(3) *Job demands:* A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

(4) *Functional capacity evaluations (FCEs):* A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

(5) *Previous PT:* There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) *Rule out surgery:* The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) *Healing:* Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum

of 4 hours a day for three to five days a week.

(8) *Other contraindications:* There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

(9) *RTW plan:* A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.

(10) *Drug problems:* There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.
(11) *Program documentation:* The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.
(12) *Further mental health evaluation:* Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.
(13) *Supervision:* Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.
(14) *Trial:* Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.
(15) *Concurrently working:* The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.
(16) *Conferences:* There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.
(17) *Voc rehab:* Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.
(18) *Post-injury cap:* The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).
(19) *Program timelines:* These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.
(20) *Discharge documentation:* At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.
(21) *Repetition:* Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Work Conditioning (WC) Physical Therapy Guidelines

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines.

WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.
Suggested Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**